DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Suite 216, The Public Ledger Building
150 S. Independence Mall, West
Philadelphia, PA 19106-3499

Mr. Vincent P. Meconi
Secretary
Delaware Health and Social Services
1901 N. Dupont Highway
New Castle, Delaware 19720

Dear Mr. Meconi,

We have reviewed the State of Delaware's request for a Medicaid home and community-based services waiver, which CMS has assigned control number 0385. This waiver proposes to serve aged and disabled, mentally retarded and developmentally disabled, and chronically mentally ill individuals, with a proposed effective date of January 15, 2001. Based on our review of the information and documentation received, we do not believe this application, as submitted, meets the statutory and regulatory requirements for approval. Please provide the following additional information and/or clarifications.

General Comments

1. The State uses a waiver application that precedes the "6/95" version of the approved format, and an outdated version of Appendix C. On December 23, 1996, a new version of Appendix C was sent out by means of a State Medicaid Director's letter. Because these materials reflect current statutory requirements and CMS policy, Delaware should resubmit its application for waiver #0385 using the most current waiver application. CMS can furnish an electronic or paper copy of the approved document upon your request. If Delaware chooses not to resubmit the application in the current approved format, please add the language and address the comments in **Attachment A**, which relates to differences between the application you submitted and the current CMS waiver application.

2. Throughout the waiver application, Delaware should be consistent when referring to the waiver (it has been referred to as the "Home and Community Based Waiver for Attendant Care," Delaware's HCBS Waiver Program for Personal Attendant," and the "Personal Assistance HCB Waiver Program"), as well as in its use of terms for the waiver services provided (Adult Day Health is referred to as Medical/Social Daycare, and Attendant Care is referred to as Personal Attendant Care).

Executive Summary

3. #3 – Under current CMS regulations, 42 CFR 441.301(b)(6), State waivers programs are not allowed to combine distinct target groups into a single waiver. Home and community-based waivers must:

be limited to one of the following targeted groups or any subgroup thereof that the State may define: (i) aged or disabled or both, (ii) mentally retarded or developmentally disabled or both, (iii) mentally ill.

The exception to this rule, as described in HCFA's Olmstead Update #4, allows for distinct target groups (i.e., acquired brain injury, muscular dystrophy, lupus) that may be categorized as either physically disabled or developmentally disabled depending on when in a person's life the condition manifests.

How does what Delaware is proposing to do under this waiver submission comport with current CMS policy?

4. #4d. – Delaware should be specific as to other targeting criteria; not refer to Appendix C-4, as the current version of Appendix C does not contain an Appendix C-4. Delaware provided information in the referenced Appendix that merely states the purpose and goals of this waiver application, not targeting criteria.

5. #7a. - Delaware indicates in the cover letter that agencies operating the waiver will provide targeted case management to their respective groups. Targeted case management is not a covered service under Delaware's current Medicaid State plan. Will case management be provided as a waiver service? If so, Delaware needs to provide associated costs as Appendix G does not reflect any cost for waiver case management. If Delaware is not providing waiver case management, this item should not be checked and should be removed from Appendix G.

6. #7.h. – In the cover letter, Environmental Modifications is listed as a waiver service. If Delaware wishes to include this service, this item should be checked.

7. #18 – Delaware must request a new effective date. New waiver submissions may not receive retroactive approval.

8. #20 – Text in the first sentence should read "Appendices A through G," not "Appendices A through F".

<u>Appendix A – Administration</u>

9. In the cover letter and in this Appendix, Delaware explains that the waiver will be operated by three distinct State agencies under the supervision of the State Medicaid Agency. To help us understand the specific roles, responsibilities and relationships between the Medicaid Agency and each of the Divisions, please submit the Memorandum of Understanding for the Divisions, describing these specifics with respect to the Attendant Care Waiver program.

<u>Appendix B1 – Services and Standards</u>

10. Personal Care, Item d.3. - <u>Frequency or intensity of supervision</u>, references 42 CFR 484.36 "Conditions of Participation for home health aide services" Please clarify. Are HHAs the only provider?

11. Item d.4. – The State indicates that personal care services are not provided under the approved State plan. This is incorrect. The State plan provides for limited personal care services. Accordingly, the State should check, "Personal care services are included in the State plan, but with limitations."

12. Adult Day Health, Item f. – Delaware does not indicate a definition for Adult Day Health. The State also does not indicate whether the cost of transportation is included in the rate paid to providers of Adult Day Health services.

13. Personal Attendant Service, Item q.

    a) Some of the language appears to be duplicative of personal care. What does the State do to prevent duplication?

    b) Text reads that "…and such core services as may be adopted by the Department by regulation." This statement, absent specificity, is not allowable. All waiver services must be identified and approved as part of a waiver application. The State should submit a waiver amendment, as needed, to add any additional types of services or change/expand the definition of an approved waiver service.

    c) How will family members be paid? What are the standards that apply to family members since they differ from those of other providers?

    d) The last sentence indicates that "Division standards apply in emergency situations." Please indicate what these standards are.

14. Adult Residential Care, Item r. – The State does not indicate a definition for Adult Residential Care. Delaware should delete this check if this is not a waiver service.

15. Clinical Support, Item s. - As indicated here, clinical support is health oriented case management. How does this differ from the targeted case management being provided? Is this service only appropriate for those individuals with mental illness? Additional information is required in the service definition to more clearly describe the service.

Appendix B2 A– Provider Qualifications

16. The State does not indicate the *Provider Type* for the Personal Emergency Response Service.

Attachment – Appendix B2

17. Personal Attendant, 3rd bullet - Text reads that consumer decisions include hiring, training, managing, paying and firing. Please clarify what the consumer's responsibility is in "paying" the provider. Also, is the ability and desire to self-direct this service mandatory for eligibility in this waiver? Must all attendant care services be consumer directed?

18. Day Services – The standards for the types of Day Services appear to limit the service to mentally retarded/developmentally disabled individuals? Is this the State's intent?

19. Contractual Issues – Please explain what is meant by "contracting agency" as it relates to the provision of Day Services to individuals receiving services from the DDDS? The State cannot restrict consumers' access to providers through any type of selective contracting. Additionally, the discussion of *Change in Placement of the Individual* in this section is not consistent with consumer direction or an individual's free choice of providers. The language used here seems to suggest that a consumer is locked into receiving services from a provider in a single contracting agency. Is this arrangement the same for other services provided within this waiver? Please explain how this aspect of the waiver is consistent with current Federal regulations.

Attachment to Appendix D-3

20. Delaware should submit a copy of the level of care assessment form used and the scoring criteria.

Appendix D-4

21. Attachment – Appendix D-4, Awareness Form – This form appears to deal only with Nursing Facility level of care individuals. Information should also be included for ICF/MR and Mentally Ill level of care individuals.

22. Freedom of Choice – This page only addresses Nursing Facility level of care.

23. Fair Hearing – This page only addresses Nursing Facility level of care.

24. Delaware needs to provide a copy of the form used for documenting Freedom of Choice.

Appendix E-2

25. Medicaid Agency approval – The description is not specific as to the role of the Medicaid agency. Delaware should also indicate what percentage of plans of care are reviewed by the Medicaid agency. As this is such a small waiver, a minimum of 10% of the plans of care is recommended.

Appendix F1 – Audit Trail

26. Billing Process and Records Retention – This application includes supported employment, prevocational services and habilitation services. The State should explain why it checked "No. These services are not included in this waiver."

Appendix G – Financial Documentation

27. G-1 – If more than one level of care is represented in this waiver, a copy of this appendix must be completed for each level of care as well as a consolidated page that reflects the weighted average of each formula and the total number of unduplicated recipients.

28. Attachment, Factor D

    a) How were the numbers determined/developed for average length of stay and number of users per month? On what did you base the estimates?

    b) Case management estimates are missing in Factor D attachment. Please complete.

    c) The chart references "cost per unit" and "units per month." Please define the "unit" of service for each waiver service.

    d) Please explain the basis for the difference in cost per unit of personal care versus attendant care services.

Demonstration of Services

29. Case management should be deleted from this section if it is not a waiver service, as well as from the Executive Summary and Appendix B.

30. Habilitation services - Day Habilitation, Prevocational Services and Supported Employment – should be broken out and have their own cost estimates.

31. Appendix G-3 – Waiting Lists – Delaware checked the statement that reads, "All recipients would be served in Nursing Facilities or ICF/MR facilities absent the waiver." Where would the chronically mentally ill be served?

Section 1915(f)(2) of the Social Security Act requires that home and community-based services waiver applications be approved, denied or have additional information requested within 90 days of receipt by CMS, or the application will be deemed approved. The 90th day on this waiver application is March 4, 2002. This constitutes a formal request for additional information, and a new 90-day period begins upon receipt of your written response. This request for a new waiver has been assigned CMS control number 0385. Please refer to this number in all future correspondence regarding this request. Please contact Ronna Bach at (215) 861-4223 if you need additional information.

Sincerely,

Claudette V. Campbell
Associate Regional Administrator
Division of Medicaid and State Operations

Enclosure

cc: Phil Soule'

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OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
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